

6813

06799

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland.		c. LENGTH OF STAY IN 1b 2 Mo.		b. COUNTY Grant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett-Weeks Nursing Home			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Storm		
3. NAME OF DECEASED (Type or print) Marshall Mertins Alderton			d. STREET ADDRESS 85 X-3		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1883
9. AGE (In years lost birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Luke Pulp & Paper Mill		11. BIRTHPLACE (State or foreign country) Allegany Co., Maryland. U.S.A.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME William Alderton			14. MOTHER'S MAIDEN NAME Annie Dean		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 236-14-5964		
17. INFORMANT Mrs. Ethel Alderton			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Prostate DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Grennized arteriosclerosis (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 10 mos.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 23 Apr 61 to 12 Jun 1961 , that (I) (we) last saw the deceased alive on 11 Jun 1961 , and that death occurred at 8:30 p. M, from the causes and on the date stated above.			22b. DATE SIGNED 14 Jun 61		
22a. SIGNATURE B. L. Grant, M. D.			22b. ADDRESS Oakland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/15/1961		
23c. NAME OF CEMETERY OR CREMATORIUM Queens Point Cemetery			23d. LOCATION (City, town, or county) Keyser, W. Va.		
24. FUNERAL DIRECTOR'S SIGNATURE Mildred Sharpless			25a. ADDRESS Blaine, W. Va.		
25b. REC'D. BY REGISTRAR Arthur S. Kraus					

HOSPITAL OR CLINIC: The law requires that the death certificate be executed while the patient is in the hospital or attending physician.

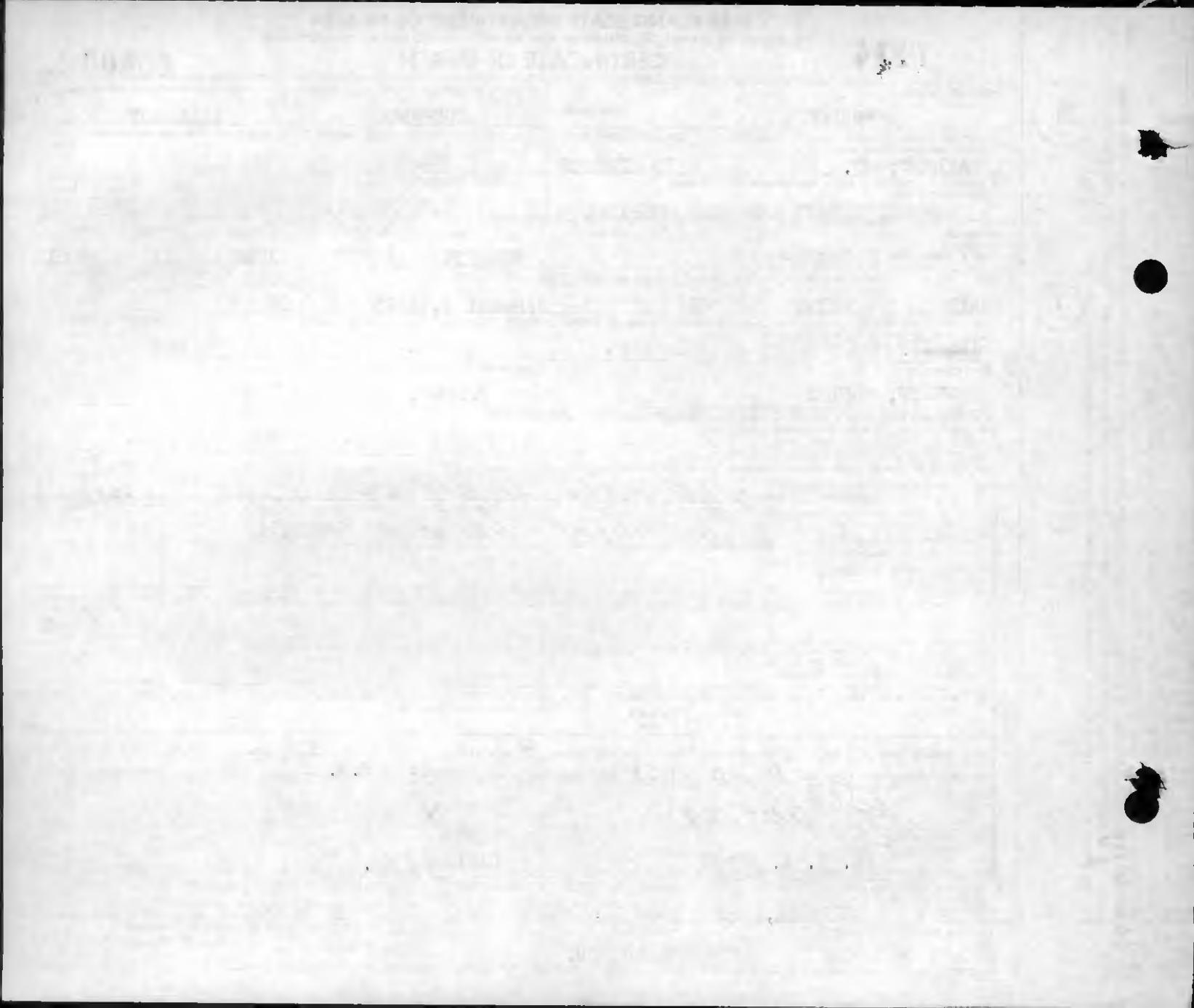
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then Please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6814

06800

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MD.		c. LENGTH OF STAY IN 1b 35 MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		0102-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 717 BEDFORD ST.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUTHER		First	Middle	Last	DATE OF DEATH JUNE 11 1961	Month	Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 9, 1875	9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID (CARPENTER)		10b. KIND OF BUSINESS OR INDUSTRY SELF EMP.		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENNETT, WESLEY				14. MOTHER'S MAIDEN NAME PERDUE, REBECCA PERDEW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CLIFFORD WILLISON		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO <i>Generalized Atherosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Generalized Atherosclerosis</i> (c) <i>Generalized Atherosclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4 Jan 1961</i> to <i>11 Jun 1961</i> , that (I) (we) last saw the deceased alive on <i>11 Jun 1961</i> , and that death occurred at <i>3:00 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>B. Grant M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1961			
22c. PHYSICIAN'S NAME (Type) DR. B. L. GRANT		22d. ADDRESS OAKLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 14, 1961		23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY		23d. LOCATION (City, town, or county) CUMBERLAND, MD. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DATE JUN 19 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6815

CERTIFICATE OF DEATH

Reg. Dist. No. 06801

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swanton Rt # 1		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Swanton Rt # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Cora Middle Alice Last Green		4. DATE OF DEATH June 17 1961			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1874	9. AGE (In years lost/birthday) 87 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cabin Run, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Gilpin			14. MOTHER'S MAIDEN NAME Mary Ellafritz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James W. Green Swanton Rt # 1, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO <i>arterio-sclerotic CVD</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>arterio-sclerosis - general</i> (c) <i>10 yrs</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1/</u> , 1961, to <u>6/17/</u> , 1961, that I last saw the deceased alive on <u>6/9/</u> , 1961, and that death occurred at <u>12:35M</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A. E. Mance</u> M.D.			ADDRESS (Street, city or town, state) <u>Oakland Md</u> DATE SIGNED <u>18 June 61</u>		
PHYSICIAN'S NAME (Type) <u>A. E. MANCE, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/61		22c. NAME OF CEMETERY OR CREMATORIAL Glendale Cemetery	
22d. LOCATION (City, town, or county) Garrett			(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald J. Minnich</u>			ADDRESS <u>Oakland, Maryland</u>		
24a. REC'D BY REGISTRAR DATE JUN 23 '61			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

STATE OF CALIFORNIA—MILITARY—MILITARY

CERTIFICATE OF THE

TO HOSPITAL OR HAVING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06802

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 5 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First STUART	Middle FAIRFAX	Last HAMILL, SR.						
4. DATE OF DEATH			Month JUNE	Day 18,	Year 19 61				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/80	9. AGE (In years lost birthday) 81 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10b. KIND OF BUSINESS OR INDUSTRY LAW		11. BIRTHPLACE (State or foreign country) MARYLAND					
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME GILMORE SEMMES HAMILL		14. MOTHER'S MAIDEN NAME ELIZABETH BISHOP		Address 47 HIGH ST., OAKLAND, MD.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-38-1383A		17. INFORMANT CLARA BELL H. BRINER (DAUGHTER)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X		INTERVAL BETWEEN ONSET AND DEATH 6 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Lymphatic thrombosis		DUE TO (b) Generalized atherosclerosis							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 19 61 to JUNE 18, 1961 , that (I) (we) last saw the deceased alive on JUNE 18, 1961 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.						22b. DATE SIGNED			
22a. SIGNATURE D. L. Grant, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>		MED. <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) D. L. GRANT, M.D.		22d. ADDRESS THIRD STREET OAKLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/61		23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery		23d. LOCATION (City, town, or county) Oakland, Maryland (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Kerald J. Minnich		ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE JUN 23 '61		25b. REGISTRAR'S SIGNATURE John S. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6817

CERTIFICATE OF DEATH

Reg. Dist. No.

06803

Page 4

TO HOSPITAL OR
may be retained
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed w/
a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write
RURAL and give nearest town)

Rural Grantsville

c. LENGTH OF STAY IN 1b

2 mo. 25 da.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Goodwill Mennonite Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

0122-2

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

d. STREET ADDRESS

Borden Road

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
MarionMiddle
TenantLast
Jenkins4. DATE
OF
DEATHJune 7
Month
Year
1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED
WIDOWED

X

NEVER MARRIED
DIVORCED

8. DATE OF BIRTH

Oct. 4th, 1876

9. AGE (In years
last birthday)

84 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

Maryland

USA

13. FATHER'S NAME

George P. Tenant

14. MOTHER'S MAIDEN NAME

Charlotte Schaub

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219AI45937A

INFORMANT

Address
Orline Mount Rd. Grantsville MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)42000
DUE TOConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.
(b)

DUE TO

(c)

Myocardial failure

Arterosclerotic heart disease

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes Mellitus · Parkinsonism.

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.20d. INJURY OCCURRED
While Not while
at work of work 20e. PLACE OF INJURY (Name, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-13, 1961, to 6-7, 1961, that I last saw the deceased
alive on 6-4, 1961, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
6-10-61

22c. NAME OF CEMETERY OR CREMATORIUM

Frostburg Memorial Park, Frostburg, Md.

22d. LOCATION (City, town, or county)

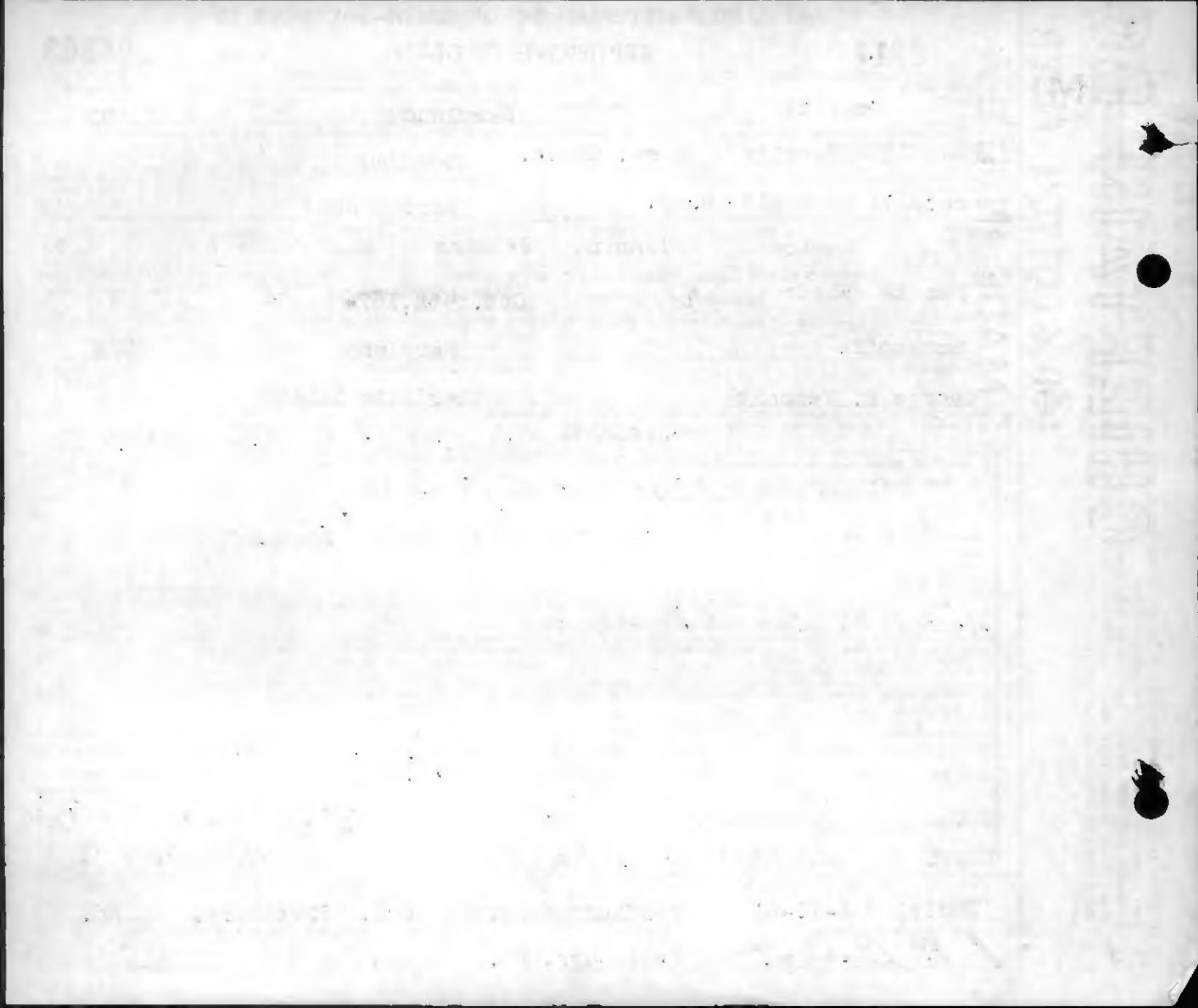
(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

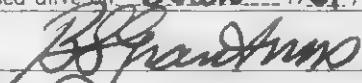
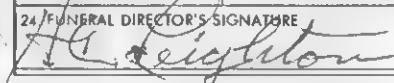
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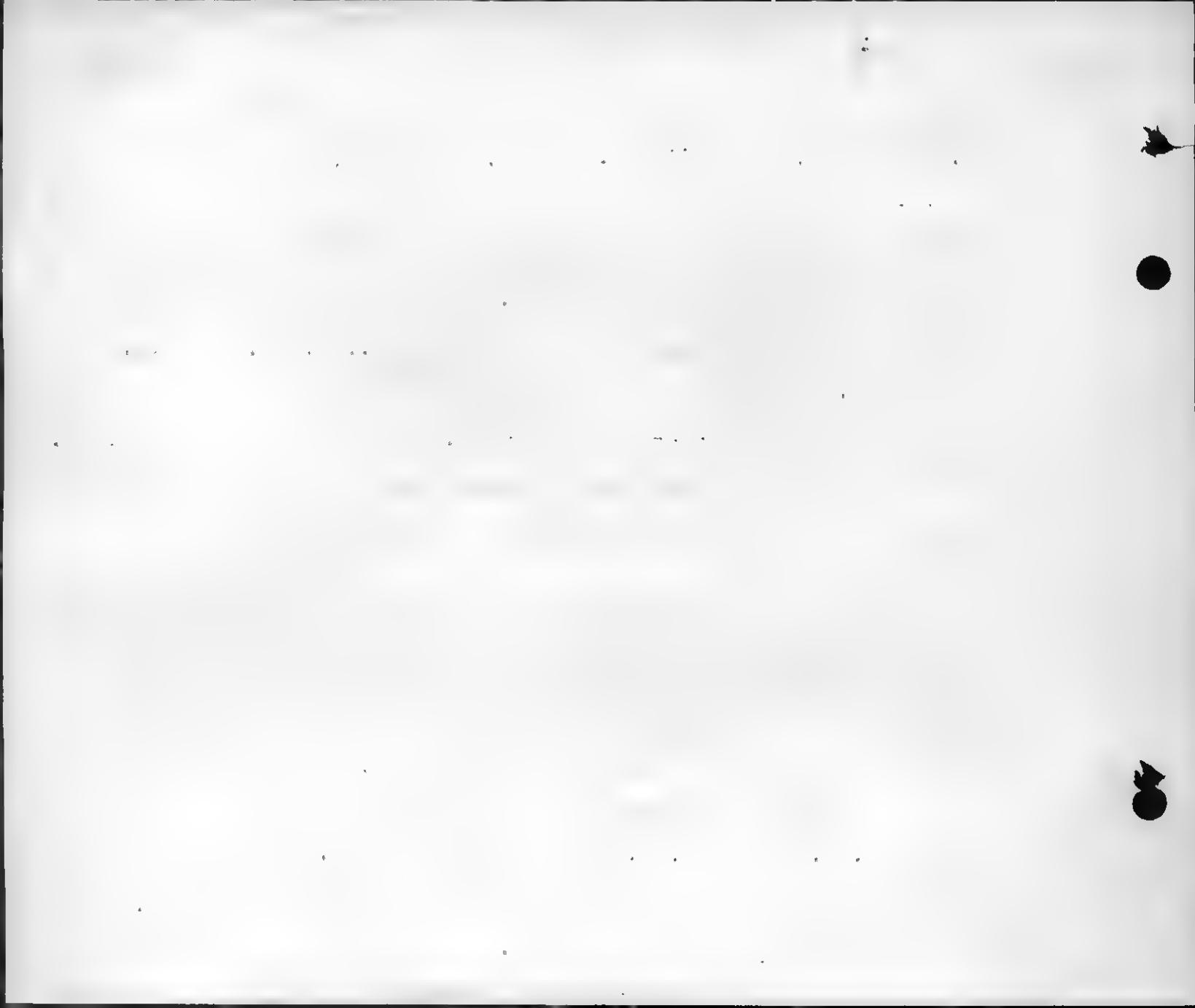
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06804

6813

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN 1b 60 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		d. STREET ADDRESS -----		
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION ---				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Charles	Middle Phillipp	Last Martin	4. DATE OF DEATH	Month June	Day 7,	Year 1961
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1876		9. AGE (In years last birthday) 85 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter & Retail Grocery		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Preston Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Britten P. Martin		14. MOTHER'S MAIDEN NAME Emma Martin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-32-8356		17. INFORMANT Britten L. Martin		Address Mt. Lake Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH 18 hrs.		
DUE TO (b) DUE TO (c)		<i>Arteriosclerosis generalized</i>						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED Whi.e at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 30 Apr. 1961 to 6 Jun. 1961 , that (I) (we) last saw the deceased alive on 6 Jun. 1961 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.								
22a. SIGNATURE 		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8 Jun 61				
22c. PHYSICIAN'S NAME (Type) B. L. Grant, M. D.		22d. ADDRESS Oakland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/1961		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oakland Cemetery		23d. LOCATION (City, town or county) Oakland, Maryland. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE Charles L. Trahan		

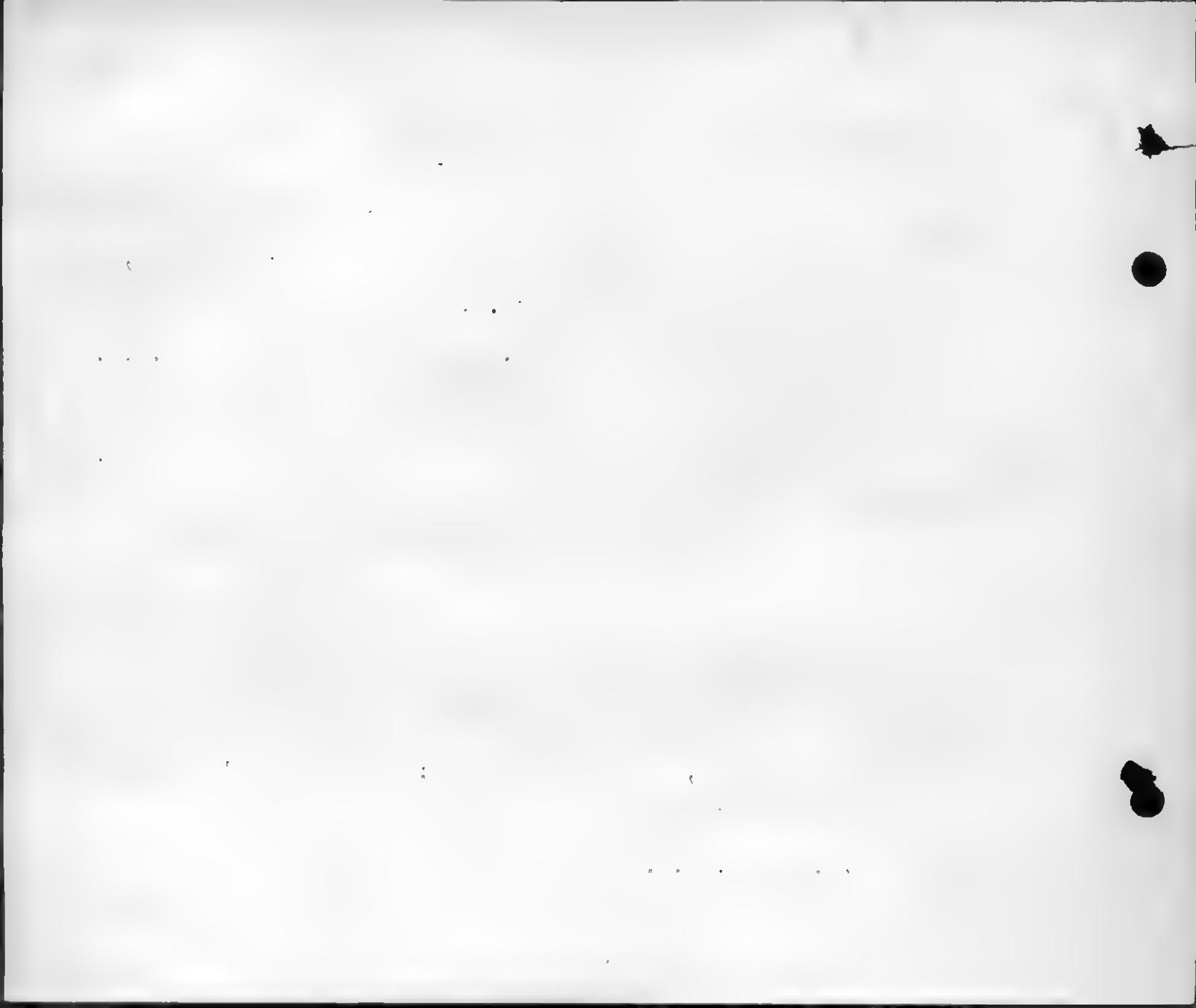


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6819

06805

1. PLACE OF DEATH a. COUNTY		CARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CA'LAND		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS ROUTE # 2 - BOX 115		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle	Last	4. DATE OF DEATH JUNE 23, 1961
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1918	
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORMAN		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM		14. MOTHER'S MAIDEN NAME CHRISTINE MC GETTIGAN Address R : 2 - BOX 115 OAKLAND, MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1W 2		17. INFORMANT (WIFE) LUCILLE MATTINGLY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 092X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost (b) DUE TO Lying cause lost (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 23, 1961 to JUNE 23, 1961 that (I) (we) last saw the deceased alive on JUNE 23, 1961, and that death occurred at 23M from the causes and on the date stated above.		22a. SIGNATURE 		22b. DATE SIGNED 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) B.L. GRANT, M.D.		22d. ADDRESS THIRD STREET, OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/61		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hoyas Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minich		23d. LOCATION (City, town, or county) Garrett, Maryland		25a. REC'D BY REGISTRAR DATE JUN 28 '61	
				25b. REGISTRAR'S SIGNATURE Gerald N. Minich	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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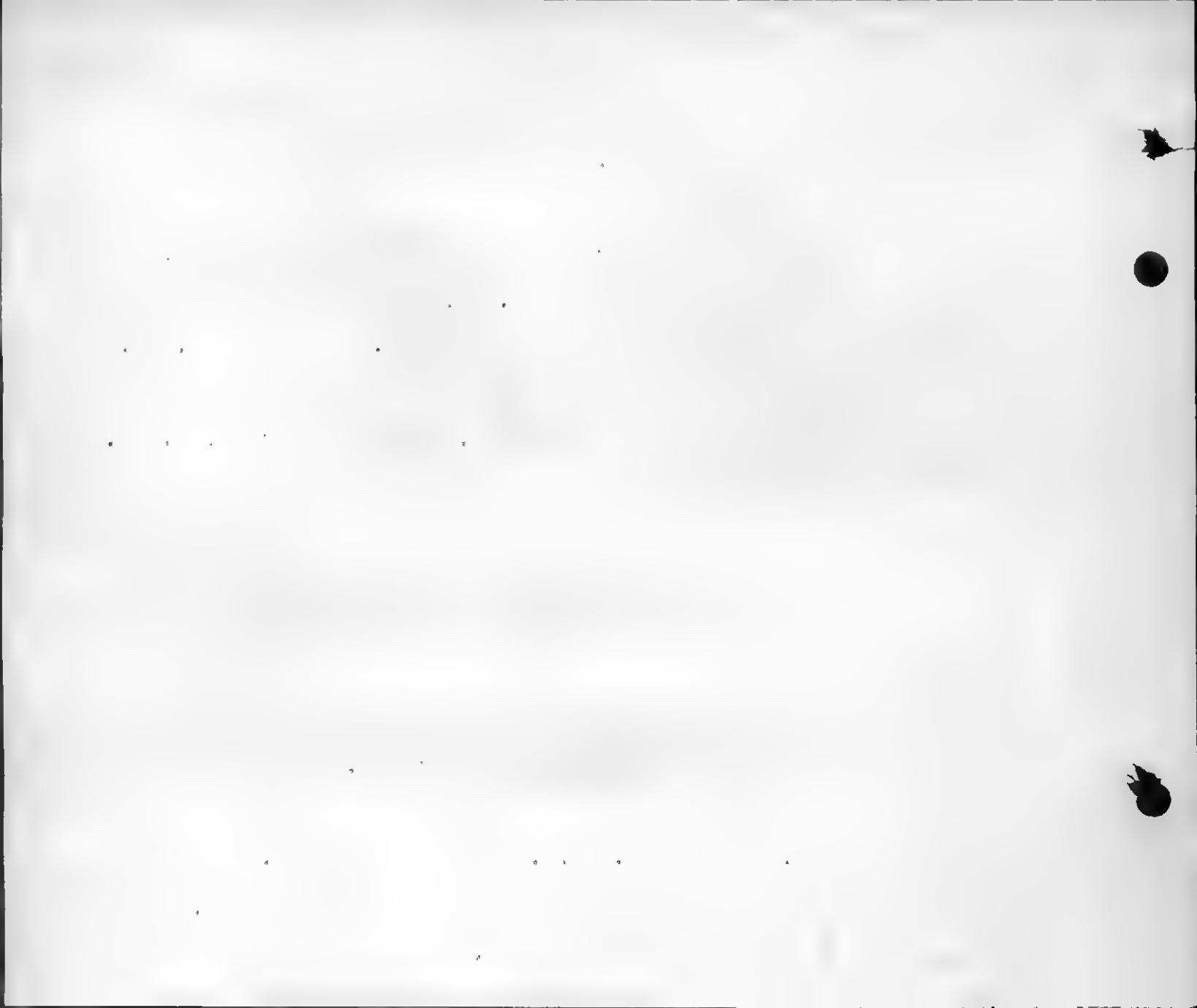
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06806

6820

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett-Weeks Nursing Home		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Jane	Last Mayle
4. DATE OF DEATH	Month June	Day 28,	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 10, 1870
9. AGE (In years last birthday) 90 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Maryland.
13. FATHER'S NAME William Lewis	14. MOTHER'S MAIDEN NAME Susan Bropes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO (If yes, give war or dates of service)	17. INFORMANT Harry H. Maylex	Address Keyser, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis - Cardo - Renal disease yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
2 Fractured Rt 4th 5-29-61. Running of air 6-1-61			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1955 to 6-28-1961 , that (I) (we) last saw the deceased alive on 6-28-1961 , and that death occurred at 7:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>James H. Feaster Jr., M.D.</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6-29-61
22c. PHYSICIAN'S NAME (Type) James H. Feaster Jr., M.D.		22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 1, 1961	23c. NAME OF CEMETERY OR CREMATORIUM Deer Park Cemetery	23d. LOCATION (City, town, or county) Deer Park, Md.
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. R. Wrightson</i>	ADDRESS Oakland, Md.	25a. REC'D BY REGISTRAR DATE JUL 3 '61	25b. REGISTRAR'S SIGNATURE <i>Curtis S. Kraus</i>



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

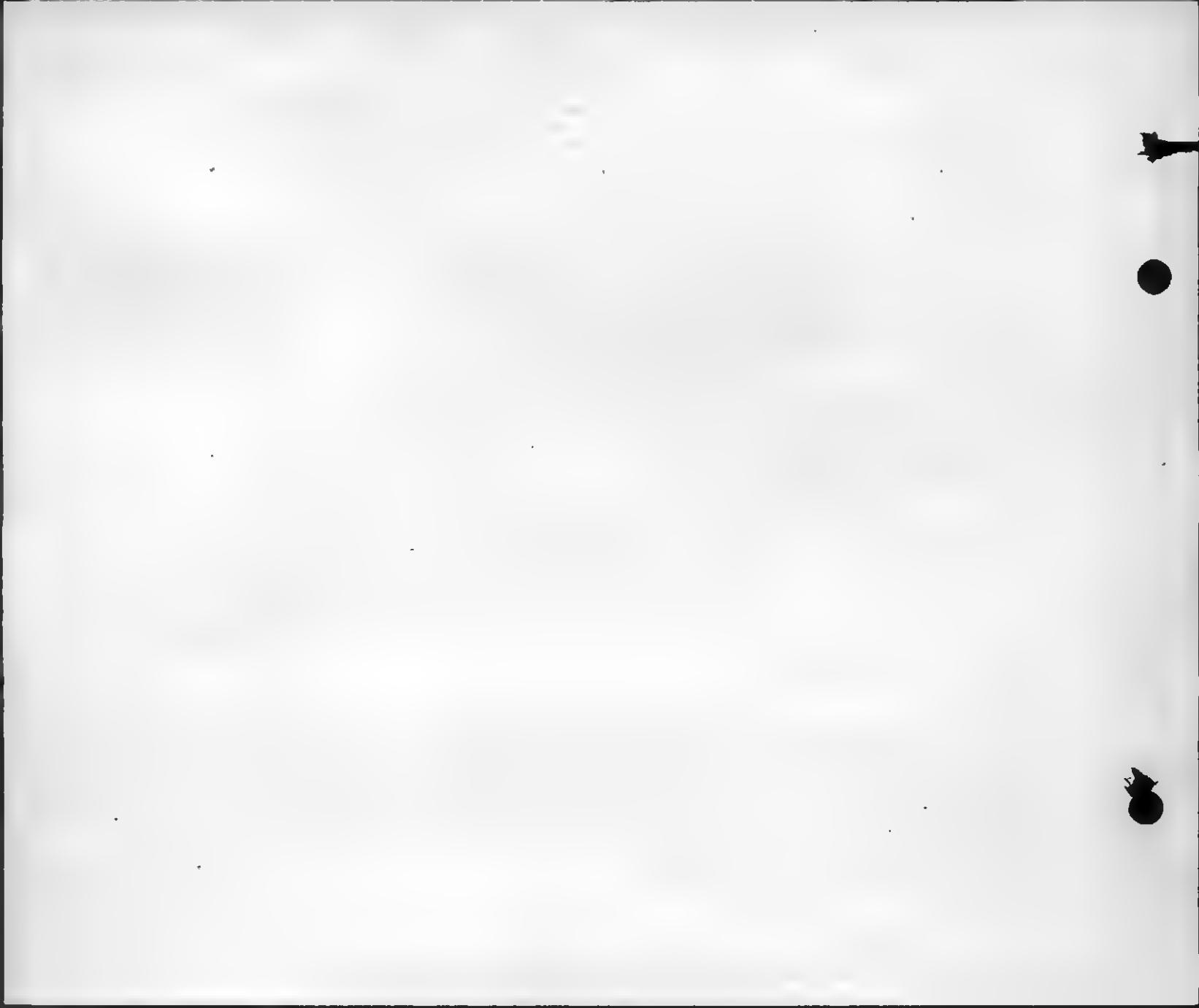
6821

CERTIFICATE OF DEATH

Reg. Dist. No.

06807

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		Garrett				
Mt. Lake Park		6 mos.		X Mt. Lake Park						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		K St.		d. STREET ADDRESS		K St.				
3. NAME OF DECEASED (Type or print)		First Dorothy	Middle Louise	Lost	4 DATE OF DEATH	Month June	Day 14	Year 1961		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS			
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 24, 1943	17 yrs	Months	Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Student		School		Oakland, Maryland		USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Arthur Moreland		Dorothy Kiser								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
no		none		Mrs. Dorothy Moreland		Mt. Lake Park, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased IntraCranial Pressure</u> DUE TO <u>1960</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Astrocytoma of Left Temporal lobe</u> DUE TO <u>2 years</u> (c) <u></u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
19										
21. I certify that I attended the deceased from <u>March 10, 1961</u> to <u>June 14, 1961</u> , that I last saw the deceased alive on <u>June 8, 1961</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>		ADDRESS (Street, city or town, state) <i>M.D. 77 Oak St. Oakland, Md. 17 Jun 61</i>								
DATE SIGNED <i>17 Jun 61</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/61		22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leroy D. physician</i>		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 22 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kiser</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6822

CERTIFICATE OF DEATH

Reg. Dist. No.

06808

1. PLACE OF DEATH a. COUNTY GARRETT			MARYLAND			2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE MD.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KITZMILLER			c. LENGTH OF STAY IN 1b 65 YRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KITZMILLER		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JAMES	Middle JOHN	Last NORMAN	4. DATE OF DEATH JUNE 9 1961	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH NOV. 21, 1878	9. AGE (In years including birthday) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN NORMAN			14. MOTHER'S MAIDEN NAME NELLIE ?			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO None			16. SOCIAL SECURITY NO 213-01-5048			17. INFORMANT MRS. CILIA NORMAN KITZMILLER, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) gout								
INTERVAL BETWEEN ONSET AND DEATH 2 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) JAN 8, 1961	
21. I certify that I attended the deceased from <u>Jan 8, 1961</u> to <u>Jan 8, 1961</u> , that I last saw the deceased alive on <u>Jan 8, 1961</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ralph Calvert</u> M.D.			ADDRESS (Street, city or town, state) Elk Garden, W. Va. DATE SIGNED JAN 8, 1961					
22a. BURIAL, Cremation, Removal BURIAL		22b. DATE THEREOF 6/12/61		22c. NAME OF CEMETERY OR CREMATORIUM NETHKEN HILL CEMETERY		22d. LOCATION (City, town, or county) ELK GARDEN		
23. FUNERAL DIRECTOR'S SIGNATURE John S. Kraus		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 13 '61		24b. REGISTRAR'S SIGNATURE John S. Kraus		



1
FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6823

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06809

1. PLACE OF DEATH
a. COUNTY

Garrett

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Deer Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Route #219, 5 Mi. N. Deer Park

3. NAME OF
DECEASED
(Type or print)

First

MARYLAND

c. LENGTH OF STAY IN 1b

60 yrs.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

V.

May 22, 1878

9. AGE (In years
last birthday)

83 yrs

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Own Farm

11. BIRTHPLACE (State or foreign country)

Maryland.

13. FATHER'S NAME

John Riley

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unknown) (If yes give war or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

--

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Myocardial Infarction, acute

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerosis

Years

Hypertension

Years

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): 19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED While
of work Not While
of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE *James H. Feaster, Jr.* M.D.

EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED
6-30-61

Address (Street, city, town, or county) Oakland, Md.

22e. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 7/3/1961

22b. DATE THEREOF

Thayerville Cemetery

22d. LOCATION (City, town, or country)

Garrett County, Md.

(State)

23. FUNERAL DIRECTOR

H.C. Leighton

ADDRESS

Oakland, Md.

24e. REG'D BY REGISTRAR

JUL 3 1961

DATE

24b. REGISTRAR'S SIGNATURE

Arthur J. Moore



6824

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06810

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland,		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 60 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland, X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 2, 10 Mi.S. of Oakland, Md.		d. STREET ADDRESS R.D.2, 10 Mi. So. Oakland,	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lydia	Middle Ann	Last Rolf
4. DATE OF DEATH	Month June	Day 16,	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1871
9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A?
13. FATHER'S NAME Casper Blamble	14. MOTHER'S MAIDEN NAME Sophia Ridder		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. - - - - -	17. INFORMANT Woodrow Rolf	Address R.D. 2, Oakland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
433.0 DUE TO <i>acute Congestive Failure</i> 1/2 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (if any). (b) <i>Atrial fibrillation</i> 2 days			
DUE TO (c) <i>arteriosclerotic cardiovascular disease</i> unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Viral Gastro Enteritis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <i>August 1961 to June 16, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 16, 1961</i> , and that death occurred at <i>10:10 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Herbert H. Leighton</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 19 June 61
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 6/19/1961	23c. NAME OF CEMETERY OR CREMATORIAL Red House Cemetery	23d. LOCATION (City, town, or county) Garrett County, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>HC Leighton</i>		ADDRESS Oakland, Md.	25a. REC'D BY REGISTRAR DATE JUN 20 '61
			25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>

4 1
FOR STATE
HEALTH DEPT.

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4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06811

1. PLACE OF DEATH

a. COUNTY

GARRETT

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

OAKLAND

c. LENGTH OF STAY IN 1b

MARYLAND
3 HOURS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

CAPRETT CO. MEMORIAL HOSPITAL

3. NAME OF
DECEASED
(Type or print)

Floyd

Henry

Shaffer

4. SEX

6. COLOR OR RACE

MALE, WHITE

7. MARRIED NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

NOV. 11, 1914

9. DATE
OF
DEATH

JUNE 21ST. 1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SHOVEL OPERATOR

State Roads

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

13. FATHER'S NAME

Charles Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

213-18-2372 Mrs. Priscilla Shaffer Rural Crellin, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

33IX

DUE TO

(b)

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

CELEBRAL HEMORRHAGE, PONTINE AREA, ACUTE 3 HRS.

YEARS

HYPERTENSION

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

OAK., MD. 6-21-61

22e. BURIAL, CREMATION, REMOVAL (Specify)

Burial 6/24/61

23. FUNERAL DIRECTOR

Garrett M. Minnich

22c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS

Garrett County Gardens Oakland, Maryland

Oakland, Maryland

22d. LOCATION (City, town, or country)

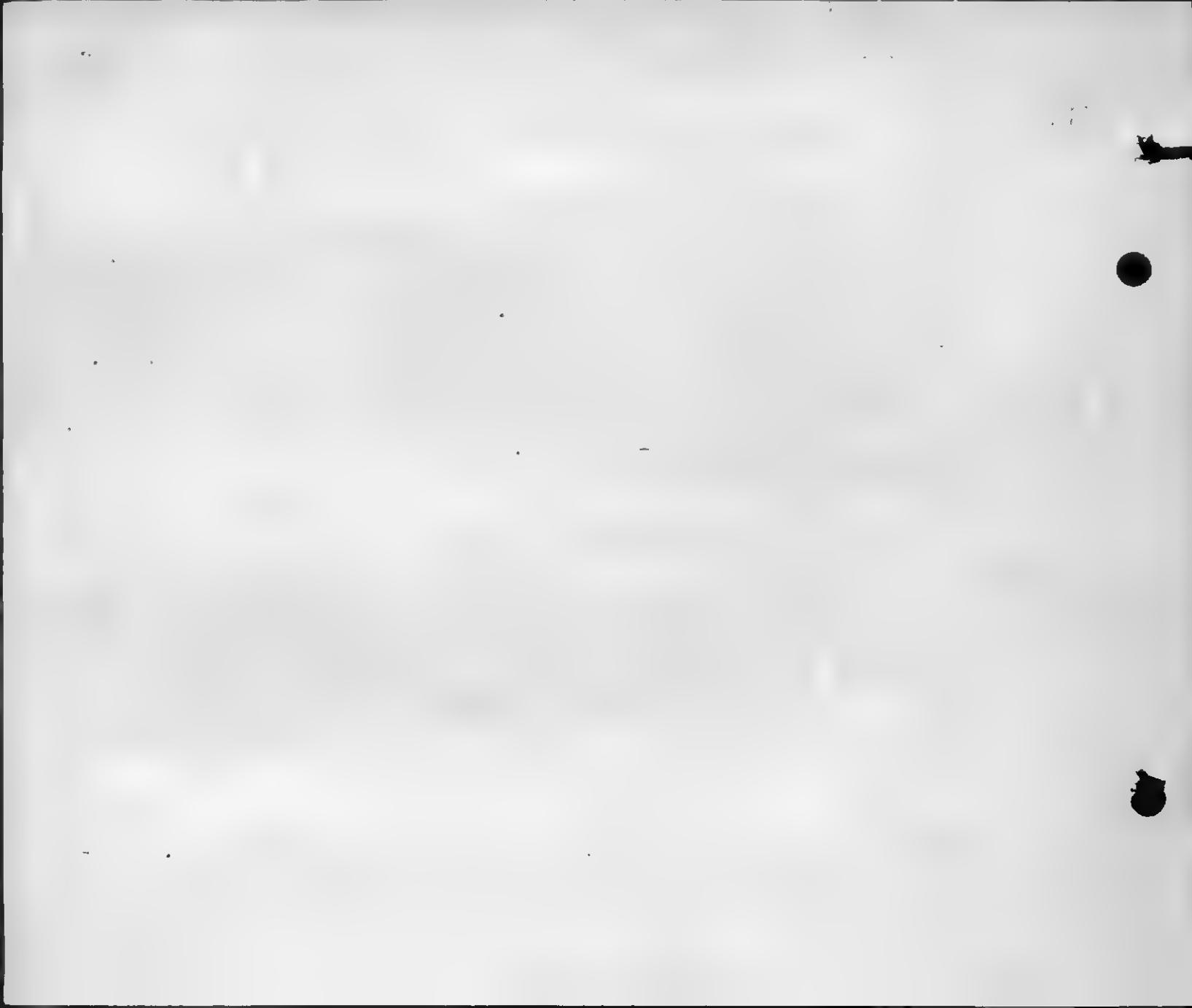
(State)

Oakland, Maryland

Oakland, Maryland

DATE JUN 23 '61

Cirrus & Krause



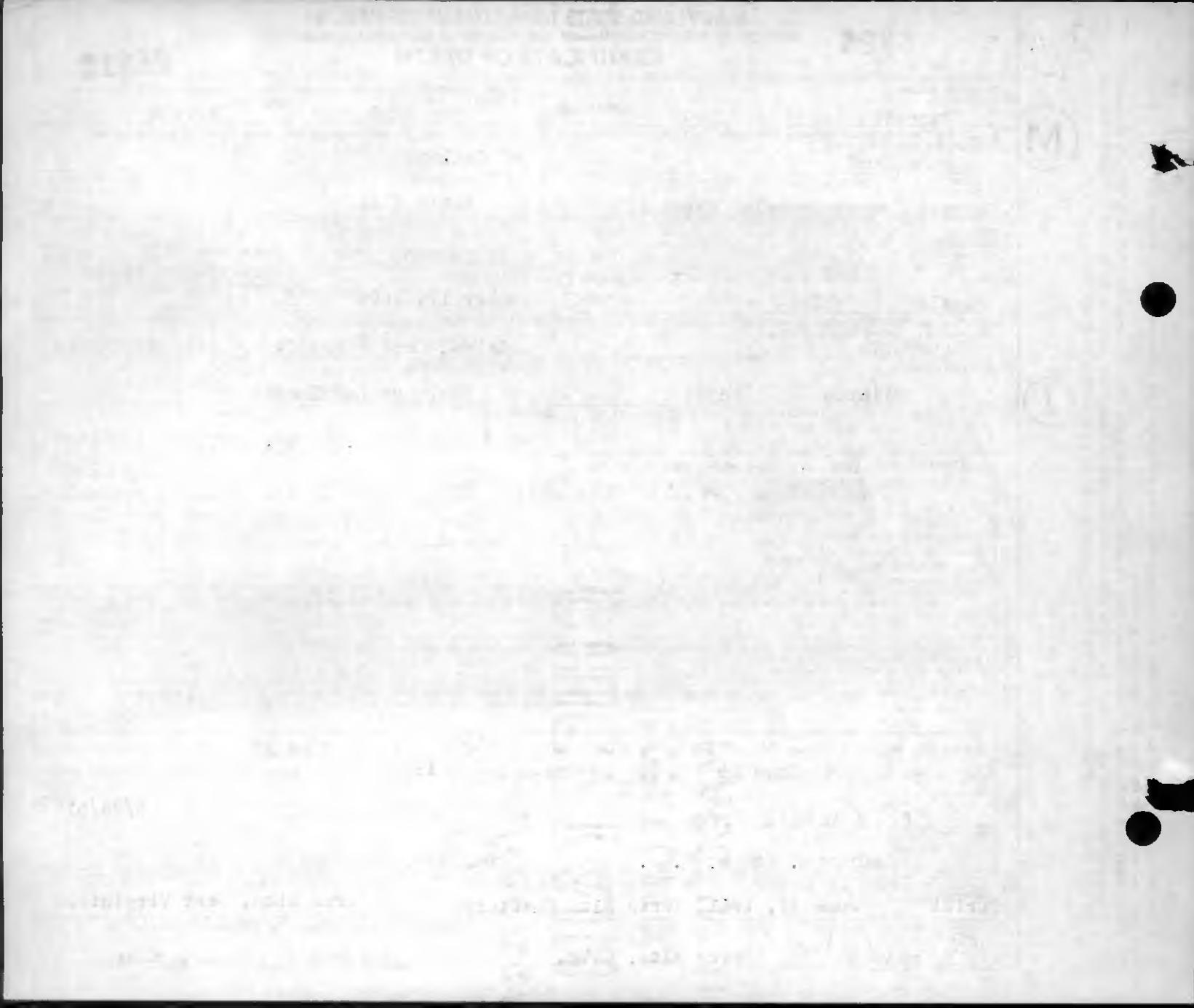
6825

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06812

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital			d. STREET ADDRESS Route # 2,		
3. NAME OF DECEASED (Type or print) Amy			First Ceatta	Middle Stockman	4. DATE OF DEATH Month June Day 25 Year 19 61
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hrs 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lehew, West Virginia	
13. FATHER'S NAME Clinton McKee			14. MOTHER'S MAIDEN NAME Florence LaFolhetta		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT Edward Stockman, Oakland, Maryland (husband)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH 6 days					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19, to June 25 , 1961, that (I) (we) last saw the deceased alive on June 25 , 1961, and that death occurred 1:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Andrew E. Mance			M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6/26/61
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.			22d. ADDRESS Oakland, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 27, 1961	23c. NAME OF CEMETERY OR CREMATORIUM Terra Alta Cemetery	23d. LOCATION (City, town, or county) Terra Alta, West Virginia. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE P. R. Watson			ADDRESS Terra Alta, W. Va.	25a. REC'D BY REGISTRAR DATE JUN 29 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Thane



may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 13 File No. 6827 6/8/61

1 6827 06813

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Garrett			
c. LENGTH OF STAY IN 1b 14 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oakland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Charles	Middle William	Last Willt		
4. DATE OF DEATH	Month June	Day 2	Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/13/1906		
9. AGE (In years last birthday) 51 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith - Construction work	11. BIRTHPLACE (State or foreign country) Oakland, Maryland	12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME George Willt	14. MOTHER'S MAIDEN NAME Zerelda Merrill XXXXXXXXXX	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or until 1910) XXXXXXX	16. SOCIAL SECURITY NO.	17. INFORMANT Harry McRobie	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Atherosclerosis of Coronary Vessels	INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland, Md.	(County)	(State)
19					
21. I certify that (I) (this hospital) attended the deceased from June 1960 to June 2 1961, that (I) (we) last saw the deceased alive on June 2 1961, and that death occurred at 7:15 M, from the causes and on the date stated above.					
22a. SIGNATURE Herbert H. Leighton	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4 June 61		
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.	22d. ADDRESS Oakland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/4/1961	23c. NAME OF CEMETERY OR CREMATORIUM Ferndale Cemetery	23d. LOCATION (City, town, or county) near Oakland, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE H. Leighton	ADDRESS Oakland, Md.	25a. REC'D BY REGISTRAR DATE JUN 5 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Evans		
VR A15 (4) 15M 9/59					

